CALIFORNIA IRONWORKERS FIELD WELFARE PLAN

131 No. El Molino Avenue Suite 330 Pasadena, CA 91101
Tel: (626) 792-7337 or (800) 527-4613

Active Employee Benefit Enrollment Form

Name: _____
Last First Middle

Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____ Gender: M F

Telephone Number: _____ Date of Birth: _____ Local Union: _____

Marital Status: ☐ Single ☐ Married / Name of Spouse: _____

☐ Divorced / Date: _____ ☐ Legally Separated / Date: _____

For any dependents to be eligible for benefits, the following documentation must be submitted along with this completed Enrollment Form:
(Please do not send original documents, copies are sufficient)

- Spouse – a copy of the certified and recorded marriage certificate *(marriage license is not acceptable)*
- Natural Child – a copy of the certified and recorded birth certificate and a copy of the dependents child's social security card
- Stepchild – a copy of the certified and recorded birth certificate and a copy of the dependents child's social security card; member must be legally married to the child's birth parent
- Legal Guardianship / Adoption – a copy of the child's certified and recorded birth certificate in addition to any pertinent court documentation

This information must be received prior to eligibility being granted for any dependent, regardless of the member's eligibility status. Also, if there has been a change in your marital status since the completion of your last Enrollment Form, please be advised that we MUST receive a complete copy of your Final Judgment of Divorce in order for an ex-spouse to be terminated or for eligibility to be granted to a new spouse. Please list below all eligible dependents *(please refer to your Health and Welfare Summary Plan Description for a list of qualifying dependents)*, which who you would like to be enrolled for eligibility under the California Ironworkers Field Welfare Plan.

DEPENDENTS TO BE ENROLLED

NAME	SSN	DATE OF BIRTH	RELATIONSHIP	GENDER
				M F
				M F
				M F
				M F
				M F

OTHER COVERAGE – You must notify the Trust Fund Office in writing if you or your dependent(s) obtain other coverage, including Medicare				
Is other coverage available to you through another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your spouse (or domestic partner) under another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your Child(ren) under another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured

I understand that the information furnished is for eligibility purposes, and I certify that the information provided on this form is correct and complete, and may be relied on in the enrollment and payment of benefits for my said dependent(s).

Member Signature: _____ Date: _____